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# LIMITATIONS ON REPRODUCTIVE AUTONOMY FOR THE MENTALLY HANDICAPPED

*George P. Smith II\**

In the United States, sterilizations are performed almost exclusively with the subject's consent today.<sup>1</sup> This is not to suggest, however, that all problems associated with the approval of the procedure itself have disappeared. The concerns are, however, decidedly different.<sup>2</sup> The principal concern is whether the procedures are truly voluntary. Classically, the individual who is to undergo the intervention is mentally incapable of giving a valid and informed consent to the operation. Here, the law's objective is to obtain a valid, substituted consent and cause to place in being those necessary standards and protections designed to assure that whatever ultimate medical decision is made is not only justified medically but also is in the best interest of the subject.<sup>3</sup> Thus, a decision made in full accordance with these criteria would ideally complement or be in agreement with the patient's very own decision if he were competent to make it. Regrettably, this ideal is not always realized, with both the laws and the practices falling short of the ideal.<sup>4</sup>

Of particular testing relevance here is the nature and dimension of "voluntariness" for sterilization of children under statutes specifying no minimum age and its performance on persons within institutional environments who give an informed consent only as a condition of discharge.<sup>5</sup> Although since the 1960's these problems have largely been resolved in the United States, the potential remains for such abuse of the principle of "voluntariness" — especially so as the rationales for sterilizations begin to shift more from eugenics to parenthood and considerations of public welfare.<sup>6</sup> As observed, "[t]he fact that some of the cases involved persons of normal mental competence and that some of the statutes aimed at the mentally incompetent — an

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1. Brakel, *Family Laws*, in *THE MENTALLY DISABLED AND THE LAW* 507 at 529 (1985).

2. *Id.*

3. *Id.*

4. *Id.*

5. *Id.*

6. *Id.*

infinitely more vulnerable group — endorse these new rationales shows that there is no reason to be complacent.”<sup>7</sup>

“Normalization” or, the development of skills that thereby enable a mentally retarded person to live in an autonomous or independent environment and be as self-sufficient as possible, is the goal of modern mental health programs.<sup>8</sup> This ideal goal of de-institutionalization has resulted in a significant number of the mentally disabled being forced to live — because of their physical and economic circumstances — with their parents.<sup>9</sup> Even with these growing efforts to place the de-institutionalized in local neighborhood or community environments, and thus curtail the costs of institutional maintenance, it is instructive to review, from an economic standpoint, the societal costs incurred in dealing with the mentally handicapped.

Unrestricted genetic transmission forces a heavy burden upon society. The Juke and Kallikak family histories reveal clearly this point. Max Juke resided in Ulster County, New York. He had two sons who married two of six sisters of a local feeble-minded family. One other sister left the area; the other three married mental defectives. From these five sisters, 2,094 direct descendants and 726 consortium descendants were traced by 1915 into fourteen states. All of them were feeble-minded and the cost to society from their welfare payments, illicit enterprises, jail terms, and prostitution brothels was \$2,516,685.00.<sup>10</sup>

Martin Kallikak, Sr. fostered a son, Martin Jr., by a feeble-minded girl during the Revolutionary War. Martin Jr. married a feeble-minded girl and they, in turn, had seven children: five of whom were similarly afflicted. From these progeny sprung 480 descendants, 143 feeble-minded, 46 normals, and 291 of unknown mental stature. When Martin Sr. returned from the War, he married a normal woman and started a line culminating in 496 descendants, all of whom were normal.<sup>11</sup>

Thirty percent of all hospitalized children have genetic diseases and six percent of the United States population is afflicted with some form of genetic ailment.<sup>12</sup> Various estimates have been made relative to the lifetime costs of various genetic diseases — often with rather astonishing results. For exam-

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7. *Id.* (footnotes omitted). See generally McIvor, *Equitable Jurisdiction to Order Sterilizations*, 57 WASH. L. REV. 373 (1982).

8. Scott, *Sterilization of Mentally Retarded Persons: Reproductive Rights and Family Privacy*, 1986 DUKE L. J. 806, 815. See Wolfensbrueger, *The Principle of Normalization and Its Implication to Psychiatric Services*, 127 AM. J. PSYCHIATRY 291 (1970).

9. Scott, *supra* note 8, at 808.

10. J. WALLIN, MENTAL DEFICIENCY 43-44 (1956).

11. *Id.* at 44-45.

12. Nat'l. Inst. for Medical Sciences, 1987: *Hearings Before the Subcomm. of Comm. on Appropriations of House of Reps.*, 99th Cong., 2nd Sess. 1093 (1987).

ple, it has been calculated that the lifetime costs of maintaining a seriously defective individual is \$250,000.00; this assumes, of course, institutionalization. Conservative estimates place the number of new cases of Down's Syndrome in the United States at five thousand or, one in every seven hundred live births. Using the \$250,000.00 figure for the cost of maintenance, the lifetime committed expenditure for new cases of Down's Syndrome standing alone comes to at least \$1.25 billion yearly, a staggering figure for but one disease entity.<sup>13</sup> It is estimated that it costs a family with a Tay-Sachs child between twenty and forty thousand dollars a year for the child's four to five years of misery.<sup>14</sup>

Another way of calculating the toll of genetic disease is to estimate the future life years costs. One widely cited estimate indicates that thirty-six million future life years are listed in the United States by birth defects — putting the figure for recognized genetic disease (eighty percent of birth defects being genetic in whole or in part) at twenty-nine million future years lost, or several times as much as from heart disease, cancer and stroke.<sup>15</sup>

Mentally retarded parents have become the focus of an intense and far-ranging debate not only among psychologists and social workers, but educators and lawyers as well.<sup>16</sup> The question put simply is: can individuals with unusually low intelligence quotients ever be "good" parents? The next two questions are linked inextricably with the first and ask: will educational or vocational training be of any real positive assistance for retarded parents who seek to give a minimum level of care to their offspring and, if not, when should the state enter and remove the children from their parental environments?<sup>17</sup> Stephen Greenspan, an educational psychologist at the University of Connecticut, raises an interesting issue: namely, since decisions about fit parenting, or more specifically *who* should be a parent, are not made on the basis of age, income or race, why then should it be based on one's intelligence quotient? An obvious reply is that without a properly functioning mind, one is not only unable to take proper care of oneself but, as in parenting, runs the risk (genetic and/or social) of hindering or preventing an off-

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13. U.S. Dep't. of Health, Education & Welfare, *What Are The Facts About Genetic Disease?*, (1978). See also, *supra* note 12.

14. Note, *The Constitutionality of Mandating Genetic Screening*, 31 CASE W. RES. 897, 900 n.27 (1981).

15. U.S. DEPT. OF HEALTH, EDUCATION & WELFARE, *supra* note 13. See, G. SMITH, GENETICS, ETHICS AND THE LAW, (1981); Smith, *Genetics, Eugenics and Public Policy*, 1986 S. ILL. L. REV. 435. See generally G. RODERICK, *MAN AND HEREDITY* (1968); H. PAPAZIAN, *MODERN GENETICS* (1967); A. SCHEINFELD, *YOUR HEREDITY AND ENVIRONMENT* (1965).

16. Kantrowitz, King & Witherspoon, *Help for Retarded Parents*, NEWSWEEK, June 23, 1986, at 62.

17. *Id.*

spring from achieving intellectual independence and thus results in a heavy economic burden to the state and its taxpayers.<sup>18</sup>

The children of retarded parents may, in turn, become as handicapped as their parents because of improper intellectual and social stimulation in the home environment. And, statistics confirm the fact that, when parents are retarded, there is a higher risk of child abuse and neglect resulting. Because of the intellectual inadequacies of the parents, the children of mentally retarded persons who might have an opportunity for "normalization" are oftentimes grid-locked into mediocrity and become models of their parents. When children are cognizant of the intellectual limitations of their parents, the rather normal rebellious attitudes of adolescence oftentimes become major problems.<sup>19</sup>

Even though the institutional cost of maintenance of the mentally handicapped during the 1970's is, now with de-institutionalization, curtailed by public health care expenditures for medication and physical care, supervisory assistance, and maintenance of the group or half-way rehabilitation homes for the retarded individuals, it could be argued that these expenditures are small, compared with the societal advantage of allowing citizens to become useful or at least semi-useful individuals. Commendable though this posture may be, the specter of the "Kallikak saga" is still ever-present and, accordingly, raises the question of what society does if and when two mentally handicapped individuals, married or unmarried, have a child. If such a hypothetical couple were to find themselves in this condition, and unable to care for themselves, the extra burden placed upon society to not only give the couple lifetime care but, additionally, to be responsible for raising the child (who itself might suffer genetic deficiencies) raises the vexatious question of whether mentally retarded individuals should be limited in their procreative freedoms. Stated otherwise, would it not be in the best interests of the retarded individuals, their potential offspring and society to prevent this scenario from being written? Economic costs are, in reality, but one factor in resolving this problem.

A recent dilemma for a young California couple illustrates the larger societal frustration and difficulty in dealing with the expanding *rights* and the all too neglected *responsibilities* of disabled Americans in general.<sup>20</sup> Tony Rios is a young thirty-four year old man confined to a wheelchair because of a

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18. *Id.*

19. *Id.* For a model statute designed to provide protection of the handicapped's right to reproductive freedom see B. SALES, D. POWELL & R. VANDUIZEND, *DISABLED PERSONS AND THE LAW* at 77-84. (1982).

20. *See Poor Disabled Couple Fights to Regain Child*, Wash. Post, Nov. 28, 1987, at 1, col. 2.

severe case of juvenile rheumatoid arthritis and congenital defects that include stunted arms. His wife Tiffany is twenty years old, has cerebral palsy and is also confined to a wheelchair. Because of their handicaps, both live on state and federal welfare funds. Already the parents of an eight month old son, the Rios' will soon have a second child. The county welfare authorities determined that the couple could see their healthy young son only for an hour each Saturday morning, with the fate of the second child yet to be decided. Both Tony and Tiffany each receive \$520.00 in monthly welfare payments and additionally some forty hours a week of care from county-paid attendants. While the couple are looking for employment, neither has found it. Tony has a high school education, while Tiffany has only completed the tenth grade. The couple was once legally separated.<sup>21</sup>

The presiding judge of the county juvenile court, Leonard P. Edwards, while sympathetic to the plight of the Rios' family observed that "the problem was lack of public money for special care."<sup>22</sup> Specifically, the judge stated: "The question is, in a world of limited resources, should you devote a large percentage of resources to one family, or do you spread those resources around to a number of families?"<sup>23</sup>

While the tragedy of the Rios' family is just that, a tragedy, it may well be compounded for them, their children *and* the state over the years to come. If they were to stay together as a married couple and have additional children, born healthy or unhealthy, the social costs to the children of being raised in the Rios' home environment would be considerable. The economic costs to society, that is, of maintaining them individually and their offspring during their lifetimes could be astronomical. Under circumstances of this nature, it would surely be within the limits of a sound public policy to educate those handicapped capable of education, as with the Rios family, that responsible child planning is a part of responsible citizenship; or, stated otherwise, that for every right of citizenship there is a coordinate duty that dictates the right be exercised reasonably (from the standpoint of economic efficiency) and responsibly.

In a related case in the District of Columbia, but not as complicated, two

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21. *Id.* at 8, col. 1.

22. *Id.*

23. *Id.* The Santa Clara County Social Services Department decided that Tiffany and Tony's first child, David, who was eleven months of age, was to be placed with a foster family interested in adoption. The second son — one month old Jesse — was initially also placed in the same foster home as his brother but was removed subsequently to an emergency shelter because of the inability of the "foster" parents to care for him. Tiffany is now seeking a divorce from Tony. *Disabled Mother's Woes Increase*, Wash. Post, Feb. 29, 1988, at A4, col. 3. See generally Note, *Unhappy Families: Special Considerations in Custody Cases Involving Handicapped Children*, 24 J. FAM. L. 59 (1985-86).

mentally retarded individuals, with IQ's under 70 (100 is considered typical), Donna and Ricardo Thornton, were featured in an episode of the popular CBS Sunday evening news program "60 Minutes," highlighting the plight of the mentally retarded in raising families.<sup>24</sup> In the District, no specific reference is made to whether mentally retarded persons may marry.<sup>25</sup> A spokesman for the District of Columbia Association for Retarded Citizens stated marriage is treated as a contractual relation entered into by two competent people. He stated "[o]nce you reach age 18, you're assumed to be competent unless someone raises the issue and you're judged by a court to be incompetent."<sup>26</sup>

Prior to the birth of their child, the Thortons were wards of the District government. They were discharged subsequently, but continue to receive social services and to live in an apartment complex supervised by a nonprofit group that assists mentally retarded people in housekeeping duties, grocery-shopping, etc..<sup>27</sup>

## II.

Modern cases support the proposition that marital and procreative decisions fall within a constitutionally protected zone of privacy.<sup>28</sup> As long ago as 1941, the United States Supreme Court declared that man possesses the basic civil right to have offspring.<sup>29</sup> More recently, the Court has held that the choice of whether to give birth is within a constitutionally protected zone of privacy.<sup>30</sup> These broad pronouncements do not force the conclusion,

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24. Gaines-Carter, *Retarded District Couple Awaits Birth of 1st Child: Some States Restrict Right to be Parents*, Wash. Post, July 1, 1986, at B1, col. 1; *Tiny Boy is Born to Retarded Couple Seen on "60 Minutes,"* Wash. Post, Dec. 8, 1986, at B3, col. 1.

25. Gaines-Carter, *supra* note 23, at B1, col. 2.

26. *Id.* at B1, col. 2 - B5, col. 1.

27. *Id.* at B5, col. 1. See Shaman, *Persons Who are Mentally Retarded: Their Right to Marry*, in 2 LEGAL, ETHICAL AND SOCIAL CHALLENGES TO A BRAVE NEW WORLD 214 (G. Smith ed. 1982) where the author argues for their right to marry and not have this right conditioned on sterilization. See also, Brakel, *supra* note 1, at 510-515 (for an analysis of the legal effect of prohibited marriages); *Id.* at 532-538 (for a state-by-state analysis of this issue). See generally Robertson, *Procreative Liberty and the Control of Conception, Pregnancy, and Childbirth*, 69 VA. L. REV. 405, 412-13 (1983).

28. See, e.g., *Eisenstadt v. Baird*, 405 U.S. 438, 452-55 (1972) (forbidding — on morality grounds — sale or gift of contraceptives to unmarried persons conflicts with fundamental constitutional rights); *Loving v. Virginia*, 388 U.S. 1, 12 (1967) (state may not infringe freedom to marry person of another race); *Griswold v. Connecticut*, 381 U.S. 479, 481-486 (1965) (statute forbidding use of contraceptives violates constitutionally protected right of marital privacy).

29. *Skinner v. Oklahoma*, 316 U.S. 535, 541 (1942). Concurring in *Griswold v. Connecticut*, Justice Goldberg commented that a compulsory birth control law unjustifiably would abridge the constitutional rights of marital privacy. 281 U.S. 479, 497 (1965) (with Goldberg, J., Warren, C.J., & Brennan, J. concurring).

30. See *Roe v. Wade*, 419 U.S. 113, 153 (1973).

however, that all restrictions on reproduction are *per se* unconstitutional. If a state may prevent a person from marrying more than one person at a time, should it not have the same power to prevent a person from having more than one or two children? The right to procreate may not include a right to breed without some restrictions.<sup>31</sup> Societal interests may be sufficiently powerful to justify at least some regulation for limitations on reproduction.<sup>32</sup>

Some legal precedents do uphold the constitutionality of eugenic sterilization. In *Buck v. Bell*,<sup>33</sup> the Supreme Court of the United States upheld a Virginia statute providing for sterilization of inmates committed to state supported institutions who were found to have a hereditary form of insanity or imbecility.<sup>34</sup> And still, today, a good number of the states have some form of compulsory sterilization legislation<sup>35</sup> — with the courts typically upholding the validity of actions brought thereunder.<sup>36</sup>

31. Golding & Golding, *Ethical and Value Issues in Population Limitation and Distribution in the United States*, 24 VAND. L. REV. 495, 511 (1971).

32. *Id.* at 512. The authors conclude, however, that the unrestricted freedom to procreate should be abridged only for a "good of momentous order." *Id.*

33. 274 U.S. 200 (1927).

34. *Id.* at 207. Justice Holmes, speaking for the Court, stated:

We have seen more than once that the public welfare may call upon the best citizens for their lives. It would be strange if it could not call on those who already sap the strength of the State for these lesser sacrifices, often not felt to be such by those concerned, in order to prevent our being swamped with incompetence. It is better for all the world, if instead of waiting to execute degenerate offspring for crime, or to let them starve for their imbecility, society can prevent those who are manifestly unfit from continuing their kind.

*Id.* See also *In re Sterilization of Moore*, 289 N.C. 95, 221 S.E.2d 307 (1976).

35. The present eugenic sterilization statutes are: CAL. PENAL CODE § 645 (West 1970); DEL. CODE ANN. tit. 16, § 5701 (1983); IDAHO CODE §§ 39-3901 to -3910 (1985); ME. REV. STAT. ANN. tit. 34B §§ 7001-17 (Supp. 1985); MINN. STAT. ANN. § 252A.13 (West 1982); MISS. CODE ANN. §§ 41-45-1 to -19 (1981 & Supp. 1985); MONT. CODE ANN. §§ 50-5-501 to -505 (1985); N.C. GEN. STAT. §§ 35-36 to -50 (1984); OR. REV. STAT. § 436.205 to -335 (1983); S.C. CODE ANN. §§ 44-47-10-44-47-100 (1985); UTAH CODE ANN. §§ 64-10-1-16 (1986); VT. STAT. ANN. tit. 18, §§ 8701-16 (1968 & Supp. 1986); VA. CODE §§ 54-325.15 (1982); W. VA. CODE §§ 27-16-1 to -5 (1986). It has been estimated that over 70,000 people have been sterilized under such statutes. STATISTICS FROM HUMAN BETTERMENT ASS'N. OF AMERICA, SUMMARY OF U.S. STERILIZATION LAWS 2 (1958).

One should distinguish these eugenic sterilization statutes from those sterilization statutes which are wholly voluntary in nature. Among the voluntary statutes are: GA. CODE ANN. §§ 84-932 (1985); N.C. GEN. STAT. §§ 90-271 to -275 (1985); N.M. STAT. ANN. §§ 24-1-14, 24-9-1 (1986); OR. REV. STAT. § 435.305 (1987). These statutes are essentially contraceptive and therapeutic and not eugenic in nature.

36. See, e.g., *Oregon v. Cook*, 9 Or. App. 224, 230, 495 P.2d 768, 771-72 (1972) (equal protection challenge based on indigency rejected); *In re Cavitt*, 182 Neb. 712-21, 157 N.W.2d 171, 178 (1968), *appeal dismissed*, 396 U.S. 996 (1970). See Sherlock & Sherlock, *Sterilizing the Retarded: Constitutional, Statutory and Policy Alternatives*, 60 N.C.L. REV. 943 (1982). See also, Dunn, *Eugenic Sterilization Statutes: A Constitutional Re-evaluation*, 14 J. FAM. L. 280 (1975).



The extension of *Buck* to sterilization of carriers of recessive defective genes cannot be accomplished without difficulty. Since its decision in that case, the Court has increasingly recognized the right to marry and have children as a basic or fundamental right and that a state must show a compelling interest in order to justify any abridgement of the right itself.<sup>37</sup> Several factors seem to indicate that the state interest is not as compelling with regard to sterilization of carriers of defective genes as it is with regard to mental incompetents. A mental incompetent may well be unable to be an adequate parent, and the burden of care therefore would fall upon the state.<sup>38</sup> Moreover, the sterilization of mental incompetents in institutions can be said to benefit them directly in that it "enable[s] those who otherwise must be kept confined to be returned to the world . . ."<sup>39</sup> The Court seemed to have assumed in *Buck*, however, that there is a strong likelihood that the child of an intellectually defective mother would in fact inherit the same defect<sup>40</sup> even though the child of two heterozygous individuals has only a one in four chance of exhibiting that defective trait.<sup>41</sup>

The distinguishing features of *Buck v. Bell* do not indicate that the state cannot offer compelling justification to warrant mandatory restriction on reproduction. Such justifications can be found in society's interest in the reduction of human suffering, and in safeguarding the health and welfare of its citizens in the allocation of economic resources and in population control.<sup>42</sup> In *Buck*, Justice Holmes stressed that, "[i]t is better for all the world . . . if society can prevent those who are manifestly unfit from continuing their kind."<sup>43</sup> Perhaps world conditions have become so complex and resources so valuable that society now has a compelling interest in restricting repro-

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37. See *Shapiro v. Thompson*, 394 U.S. 618, 638 (1969).

38. See *Oregon v. Cook*, 9 Or. App. 224, 230, 495 P.2d 768, 771-72 (1972).

39. *Buck v. Bell*, 274 U.S. 202, 208 (1927). The Court's rationale acquires additional significance because it became the basis for distinguishing *Buck* in the case of *Skinner v. Oklahoma* where the High Court invalidated a statute providing for the sterilization of habitual criminals. The *Skinner* Court concluded that the questioned statute violated the fourteenth amendment's equal protection clause. See 316 U.S. at 542 (1942).

40. The statute challenged in *Buck* required only that experience demonstrate that heredity plays an important role in the transmission of the mental defect. See 274 U.S. at 206. The inmate involved, however, was the daughter of a feeble-minded mother. *Id.* at 205.

See generally, Murray, *Marriage Contracts for the Mentally Retarded*, 21 CATH. LAW. 182 (1975).

41. See Waltz & Thigpen, *Genetic Screening and Counseling: The Legal and Ethical Issues*, 68 N.W. U.L. REV. 696, 721, n.131 (1973).

42. 274 U.S. 200 (1927). See Lamdam, *The History of Human Sterilization in the United States: Theory, Statute and Adjudication*, 23 ILL. L. REV. 463 (1929); Baron, *Voluntary Sterilization of the Mentally Retarded*, in GENETICS AND THE LAW 267 (A. Milunsky, G. Annas eds. 1976); Rothman, *Sterilizing the Poor*, 14 SOCIETY 36 (1977).

43. 274 U.S. at 207.

duction by those, who although not "manifestly unfit" themselves, perpetuate human suffering by giving birth to genetically defective offspring.

In attempting to fill the significant statutory vacuum found within the whole scheme of procedural protections applicable to sterilization proceedings, and to distinguish or define when procedure shades into substantive standards or, more specifically, *what* must be alleged, shown and reviewed as opposed to how or who must undertake it, the courts have assumed the legislative function. In the statutory void found within the State of Washington, the Supreme Court of the state, in the case of *In re Guardianship of Hayes*<sup>44</sup>, prescribed the following "sterilization guidelines:"

The decision can only be made in a superior court proceeding in which (1) the incompetent individual is represented by a disinterested guardian ad litem, (2) the court has received independent advice based upon a comprehensive medical, psychological, and social evaluation of the individual, and (3) to the greatest extent possible, the court has elicited and taken into account the view of the incompetent individual.

Within this framework, the judge must first find by clear, cogent and convincing evidence that the individual is (1) incapable of making his or her own decision about sterilization, and (2) unlikely to develop sufficiently to make an informed judgment about sterilization in the foreseeable future.

Next, it must be proved by clear, cogent and convincing evidence that there is a need for contraception. The judge must find that the individual is (1) physically capable of procreation, and (2) likely to engage in sexual activity at the present or in the near future under circumstances likely to result in pregnancy, and must find in addition that (3) the nature and extent of the individual's disability, as determined by empirical evidence and not solely on the basis of standardized tests, renders him or her permanently incapable of caring for a child, even with reasonable assistance.

Finally, there must be no alternatives to sterilization. The judge must find that by clear, cogent and convincing evidence (1) all less drastic contraceptive methods, including supervision, education and training, have been proved unworkable or inapplicable, and (2) the proposed method of sterilization entails the least invasion of the body of the individual. In addition, it must be shown by clear, cogent and convincing evidence that (3) the current state of scientific and medical knowledge does not suggest either (a) that a reversible sterilization procedure or other less drastic contraceptive method will shortly be available, or (b) that science is on the

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44. 93 Wash.2d 8, 608 P.2d 635, 641 (1980).

threshold of an advance in the treatment of the individual's disability.<sup>45</sup>

These "guidelines" are as detailed as those found in any of the sister-state statutory classifications in other jurisdictions and are properly regarded as the very latest in procedural "progressivism."<sup>46</sup>

The aftermath of *Hayes* has seen most laws embodying "strict procedural and substantive requirements creat[ing] a strong presumption against sterilization";<sup>47</sup> and, furthermore, presuming such a conflict of interest exists between the parent and the child as to exclude the parents from assuming a role in decision making here.<sup>48</sup> Thus, modern courts proceed to evaluate a decision regarding sterilization within a formal or "semi-adversarial" proceeding where the retarded person is represented by an attorney or guardian *ad litem* who is often directed to oppose the sterilization petition.<sup>49</sup>

These modern laws also seek to impose rigorous substantive criteria for the court to assess in their deliberations.<sup>50</sup> For example, some mandate inquiry into the individual's ability to reproduce<sup>51</sup> and whether sexual activity is imminent.<sup>52</sup> Additionally, the petition is often required to present proof that less invasive forms of contraception have been either tried or are considered infeasible.<sup>53</sup> In some jurisdictions, the courts will evaluate a mentally handicapped individual's capacity to care for a child which may be born subsequently,<sup>54</sup> and, furthermore, require proof that the sterilization in issue is medically essential and in the best interest of the individual's physical or mental health.<sup>55</sup>

The following variables have been determined to be *without* the reach of a court's consideration in ruling on a petition for sterilization: the need to protect the state from genetic and financial burdens imposed upon it by the

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45. *Id.* at — The various provisions with state statutory enactment relevant to pre-hearing and post hearing sterilization proceedings are presented in tabular form in Brakel, *supra* note 1, at 552-57.

46. Brakel, *supra* note 1 at 528.

47. Scott, *supra* note 8, at 818.

48. *Id.*

49. *Id.* at 819.

50. *Id.*

51. *E.g.*, CONN. GEN. STAT. ANN. § 45-78p(d) (West Supp. 1986); ME. REV. STAT. ANN. tit. 34-B, § 7011 (West Supp. 1986).

52. *E.g.* UTAH CODE ANN. § 64-10-8(1)(f) (1983); VA. CODE ANN. § 54-325.12.A.1 (1982).

53. *See, e.g.*, MINN. STAT. § 252 A.13.4 (1982); W. VA. CODE § 7-16-1 (1980).

54. *See, e.g.*, Conn. Gen. Stat. Ann. § 45-78p(d) (6) (West Supp. 1983); VA. CODE ANN. § 54-325.12.A.4 (1982).

55. *See, e.g.*, CONN. GEN. STAT. ANN. § 45-78p(d)(8) (West Supp. 1983); ME. REV. STAT. ANN. tit. 34-B, § 7013.5 (Supp. 1984).

children of retarded persons,<sup>56</sup> parental interest in seeking to prevent the child from an unwanted pregnancy, or avoiding the difficulties or inconveniences associated with hygienic menstrual practice, or wishes to reduce the stressful situations that arise from the associated care that is given to mentally retarded persons who are sterilized.<sup>57</sup> Some case determinations state clearly that before sterilization is ordered, it must first be shown by the parents that they are acting in good faith and concerned only with their child's best interest.<sup>58</sup>

Four types of legal rules comprise what is to be regarded as the substantive criteria that, in turn, shapes ultimate decisions regarding sterilization: (1) the "mandatory criteria" that allows a court to authorize sterilization only where specific findings are made; (2) the more flexible "discretionary best interest" that forces a court to evaluate or weigh a set of designated criteria in reaching a determination regarding whether an order of sterilization is in the best interest of the incompetent person; (3) the "substituted judgment" approach where the *Hayes* criteria is followed, together with any other relevant factors considered significant to reach a decision the disabled individual would make for himself if competent; and (4) those rules that some courts follow merely prohibiting sterilization where it is determined the candidate for intervention is incompetent to make an informed consent to the procedure itself.<sup>59</sup> The public policies behind these rules run the gamut from protecting only the right to procreate, as with the fourth type, to striking a balance between parentalism and state interference in the first, second and third.<sup>60</sup>

Since the decision of the United States Supreme Court in *Stump v. Sparkman*,<sup>61</sup> declaring an Indiana circuit court judge immune from liability for ordering the sterilization of a "somewhat" retarded child on her mother's petition, in a suit brought subsequently by that incompetent, the vast majority of state courts before which the question has been raised have determined their inherent equitable authority, in the absence of statute, to order sterilizations of the mentally retarded.<sup>62</sup>

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56. *In re Grady*, 85 N.J. 235, 262 n.8, 426 A.2d 467, 481 n.8 (1981); *In re Terwilliger*, 304 Pa. Super. 553, 564, 450 A.2d 1376, 1382 (1982).

57. Scott, *supra* note 8, at 822.

58. *See In re C.D.M.*, 627 P.2d 607, 613 (Alaska 1981); *In re Penny N.*, 120 N.H. 269, 414 A.2d 541 543 (1980); *See also* CONN. GEN. STAT. ANN. § 45-78p(d)(7) (West Supp. 1986).

59. Scott, *supra* note 8, at 822-23.

60. *Id.* at 823-24. *See also*, Comment, *Sterilization Technology and Decisionmaking: Rethinking the Incompetent's Right*, 2 J. CONTEMP. H. L. & POL'Y. 275, 301, 304 (1986).

61. 435 U.S. 349 (1978).

62. Scott, *supra* note 8, at 817 n.32.

The extent to which American courts would allow themselves to allow sterilization for purposes purely of contraception, is difficult to ascertain. The *Hayes* Court guidelines<sup>63</sup> indicate a considerable latitude for the courts as they act under a best interest test or substituted judgment test.<sup>64</sup>

### III.

On October 23, 1986, the Canadian Supreme Court, in the case of *Re Eve*,<sup>65</sup> held that the sterilization of a twenty-four year old woman suffering from extreme expressive aphasia could be legally sterilized.<sup>66</sup> More specifically, the court held that a non-therapeutic sterilization, without consent, of a mentally retarded person under its broad historical *parens patriae* power can never be safely determined to be for the benefit of that person.<sup>67</sup>

The evidence established that Eve was, unquestionably at least mildly to moderately retarded. She has some learning skills, but only to a limited level. She is described as being a pleasant and affectionate person who, physically, is an adult person, quite capable of being attracted to, as well as attractive to, the opposite sex. While she might be able to carry out the mechanical duties of a mother, under supervision, she is incapable of being a mother in any other sense. Apart from being able to recognize the fact of a family unit, she would have no concept of the idea of marriage, or indeed, the consequential relationship between intercourse, pregnancy and birth.<sup>68</sup>

Eve's mother originally made an application for permission to consent to the sterilization of her daughter who was, as noted, mentally retarded.<sup>69</sup> The appeal to the Supreme Court was maintained by the guardian *ad litem* of Eve from a judgment by the Prince Edward Island Supreme Court allowing an appeal by Eve's mother from a judgment dismissing her application for a sterilization order.

Justice McQuaid of the Prince Edward Island Supreme Court determined that the court had no authority or jurisdiction to authorize a surgical procedure on a mentally retarded person, the intent and pur-

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63. 608 P.2d 635, 637-8 (Wash. Sup. Ct. 1980).

64. See *In re Grady*, 85 N.J. 235, 426 A.2d 467 (1981); *In re Moe*, 432 N.E.2d 712 (Mass. Sup. Ct. 1982); *Re A.W.*, 637 P.2d 366 (Colo. Sup. Ct. 1981).

See generally, Lachance, *In re Grady: The Mentally Retarded Individual's Right to Choose Sterilization*, 6 AM. J.L. & MED. 559 (1981).

65. (1987), 31 D.L.R. (4th) at 1.

66. *Id.* Expressive aphasia is recognized as a condition where the patient has no ability to communicate in outward thoughts or concepts easily perceivable. *Id.* at 4.

67. *Id.* at 32.

68. *Id.* at 4.

69. *Id.* at 3.

pose of which was solely contraceptive. It followed that, except for clinically therapeutic reasons, parents or others similarly situated could not give a valid consent to such a surgical procedure either, at least in the absence of clear and unequivocal statutory authority.<sup>70</sup>

In accepting this view and building upon it, Justice LaForest of the Canadian Supreme Court found the proposal for Eve's sterilization was not sought to treat any of her medical problems and, thus, the real purpose was purely non-therapeutic.<sup>71</sup> Rather, the sterilization was sought in order to not only save Eve from the trauma of the birthing process, but to relieve her mother from the growing anxiety about the real possibility of Eve's becoming pregnant and of her being saddled with the care and ultimate responsibility for raising Eve's child.<sup>72</sup>

Justice LaForest went to considerable effort to discuss and analyze the distinctions between the court's wardship and *parens patriae* powers, acknowledging that with children, the chancery courts have a custodial jurisdiction that allows them to make children wards of the court, but that this jurisdiction does not extend to mentally incompetent adult persons.<sup>73</sup> Although the wardship cases offer a helpful guide to the exercise of the *parens patriae* power in cases involving adults, the real bases of this power over the mentally incompetent have been "lost in the mists of antiquity."<sup>74</sup> It is thought, however, that the origins tie to either a general consensus or an early statute pertaining to the need of the Crown to provide care for individuals of unsound mind who were unable to perform their feudal duties.<sup>75</sup> Despite the vagueness surrounding the historical etiology of the *parens patriae* jurisdiction, it appears clear that this jurisdiction "was never limited solely to the management and care of the estate of a mentally retarded or defective person."<sup>76</sup> Indeed, the Crown has an inherent jurisdiction to do what is for the benefit of the incompetent. Its limits have not, and cannot, be defined.<sup>77</sup>

"Wardship of children had a quite separate origin as a property right arising out of the feudal system of tenures. The original purpose of the wardship jurisdiction was to protect the rights of the guardian rather than of the ward."<sup>78</sup>

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70. *Id.* at 5.

71. *Id.* at 9.

72. *Id.*

73. *Id.* at 15.

74. *Id.* at 14.

75. *Id.*

76. *Id.* at 16.

77. *Id.*

78. *Id.* at 14.

The most current exercise of Canadian law based upon an exercise of the *parens patriae* jurisdiction to order sterilization (here, a hysterectomy) for therapeutic reasons for a seriously retarded child is found in the 1985 case of *Re K and Public Trustee*.<sup>79</sup> The controlling factor in the sterilization order here "was the child's alleged phobic aversion to blood, which it was feared would seriously affect her when her menstrual period began."<sup>80</sup> The opinion stressed, however, that the case should not be regarded "as a precedent to be followed in cases involving sterilization of mentally disabled persons for contraceptive purposes."<sup>81</sup>

Justice LaForest summed up his views of the instant case by observing that,

The grave intrusion on a person's rights and the certain physical damage that ensues from non-therapeutic sterilization without consent, when compared to the highly questionable advantages that can result from it, have persuaded me that it can never safely be determined that such a procedure is for the benefit of that person. Accordingly, the procedure should never be authorized for non-therapeutic purposes under the *parens patriae* jurisdiction . . . .<sup>82</sup> it is difficult to imagine a case in which non-therapeutic sterilization could possibly be of benefit to the person on behalf of whom a court purports to act, let alone one in which that procedure is necessary in his or her best interest.<sup>83</sup>

The Lord Lords have, obviously shown themselves to be humanely sensitive, in a most reasonable and balanced manner, to an equally sensitive and complex issue of equality of reproductive opportunity for the mentally handicapped versus the responsibility of the family and the state to act responsibly in implementing this right. Instead of structuring artificial distinctions that in turn present the basic issue in black and white terms as the Canadian Supreme Court did, the Lord Lords have demonstrated a sophisticated, compassionate and contemporary attitude that, in turn, should influence those jurisdictions of the common law heritage and thereby assist them in their efforts to confront this volatile issue.

On April 30, 1987, the House of Lords held, in the case of *Re B*,<sup>84</sup> that a mentally handicapped young girl of seventeen years of age, who had a mental age of five or six, spoke in one or two word sentences and was addi-

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79. (1985), 19 D.L.R.(4th) 255, 63 B.C.L.R. 145 [1985], 4 W.W.R. 724 as cited in 31 D.L.R.(4th) at 2.

80. 31 D.L.R.(4th) at 22.

81. *Id.*

82. *Id.* at 32.

83. *Id.*

84. [1987] 2 All E.R. 206.

tionally subject to epileptic seizures, could be sterilized by occlusion of the Fallopian tubes and not hysterectomy. It was held that this was for her own welfare and in her best interests.<sup>85</sup> Although not capable of consenting to marriage, B exhibited a "normal" sexual drive and it was maintained that if she were to be given contraceptive drugs (evidence in actuality being presented that showed it would be very difficult if not impossible to maintain her on oral contraceptives), these would react adversely with drugs administered presently to control her mental instability and epilepsy. Thus, sterilization was the only effective intervention — outside of institutionalization, for which there was reluctance by the local authorities to pursue, to prevent the problems and complications attendant with motherhood for the young girl.<sup>86</sup> Expert evidence was adduced showing "that it was vital that she not [be permitted to] become pregnant,"<sup>87</sup> this being presented as such by a pediatrician, a social worker and a gynecologist. The girl's mother supported the initial application for sterilization, but the Official Solicitor, assuming the role of the minor's guardian *ad litem*, opposed it. After the application was granted, the Solicitor appealed to the Court of Appeal where his case was dismissed. He then took his appeal to the House of Lords.<sup>88</sup>

Lord Hailsham of St. Marylebone LC, in his opinion, stressed a theme that was developed by the other Law Lords hearing this appeal and was also evident in the lower court considerations of the case: namely, the desire of the authorities to afford the young girl "as much freedom as possible"<sup>89</sup> so that she could lead a "normal" life consistent with her handicap. Since she was unable to understand and thus was unable to learn the causal relationship between intercourse, pregnancy and the birth of children, it was determined she would be incapable of giving a valid consent to marriage.<sup>90</sup>

As she menstruates irregularly, pregnancy would be difficult to detect or diagnose in time to terminate it easily. Were she to carry a child to full term she would not understand what was happening to her, she would be likely to panic, and would probably have to be delivered by Caesarian section, but, owing to her emotional state, and the fact that she has a high pain threshold she would be quite likely to pick at the operational wound and tear it open. In any event, she would be terrified, distressed and extremely violent' during normal labor. She has no maternal instincts and is not likely to develop any. She does not desire children, and, if she bore a child,

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85. *Id.* at 212.

86. *Id.*

87. *Id.*

88. *Id.*

89. *Id.* at 207, 217.

90. *Id.* at 212.



would be unable to care for it.<sup>91</sup>

The other alternatives to sterilization, incarceration and the administered use of an oral contraceptive such as progesterone, were held by the Lords as impractical. Incarceration would reduce B's liberty and thus "be gravely detrimental to the amenity and quality of her life."<sup>92</sup> The use of an oral contraceptive over the next twenty-five or thirty years or during the period of fertility, had "only a 40% chance of establishing an acceptable regime, and has serious potential side effects."<sup>93</sup> The evidence also showed that in light of B's dramatic shifts in mood and her considerable physical strength, "it would not be possible" to guarantee the administration of the necessary daily dose of contraceptive drugs. The attending social worker testified that when B got into "one of her moods," it was impossible to "give her a pill."<sup>94</sup>

In concluding the sterilization should be ordered, Lord Hailsham found himself in complete agreement with the trial court and the Court of Appeal when they concluded the paramount test was whether the [sterilization] action would advance the welfare of the young girl.<sup>95</sup> Taking sharp issue with the Canadian case of *Re Eve*<sup>96</sup> and Justice LaForest's distinction between sterilizations for therapeutic and non-therapeutic purposes and his conclusion that such acts should never be allowed for non-therapeutic purposes, Lord Hailsham concluded that the LaForest position here was "in startling contradiction[s] to the welfare principles which should be the first and paramount consideration in wardship cases."<sup>97</sup> The distinctions between therapeutic and non-therapeutic purposes were discounted further as "totally meaningless" and — furthermore — "quite irrelevant to the correct application of the welfare principle."<sup>98</sup>

Lord Bridge of Harwich stressed, in his opinion, that the case had nothing to do with the application of eugenic theories "or with any attempt to lighten the burden which must fall on those who have the care of the ward. It is concerned, and concerned only, with the question of what will promote the welfare and serve the best interests of the ward."<sup>99</sup> Returning to *Re Eve*, Lord Bridge referred to "the great privilege of giving birth" and concluded in the instant case before him on appeal, that the unstable mental and physical condition of the ward rendered her effectively "incapable of ever exercis-

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91. *Id.*

92. *Id.*

93. *Id.*

94. *Id.*

95. *Id.* See, Grubb & Pearl, *Sterilization and The Courts*, 46 CAMB. J. J. 439 (1987).

96. (1986) 31 D.L.R.(4th) 1.

97. 2 All E.R. 206, 213 (1987).

98. *Id.*

99. *Id.*

ing that right or enjoying that privilege.”<sup>100</sup> To allow the ward to become pregnant “would be an unmitigated disaster.”<sup>101</sup> Lord Brandon of Oakbrook expressed succinctly his agreement with Lord Halisham, Lord Bridge and Lord Oliver in agreeing to dismiss the appeal.<sup>102</sup> In elaborating upon the procedure under which an application for sterilization could be brought, Lord Templeman stated his opinion that the sterilization of a girl under the age of eighteen years could only be allowed with the permission of a High Court judge — otherwise, the physician performing the sterilization, even with the consent of the girl’s parents, could well be held liable in either criminal, civil or even professional disciplinary proceedings.<sup>103</sup> “A court exercising the wardship jurisdiction emanating from the Crown is the only authority which is empowered to authorize such a drastic step as sterilization after a full and informed investigation.”<sup>104</sup> With such a procedure, he concluded that applications for sterilization rarely would be made.<sup>105</sup> He concluded by observing that it would be “cruel” to expose the young girl in the present appeal “to an unacceptable risk of pregnancy.”<sup>106</sup>

Finally, Lord Oliver of Aylmerton reiterated the point that the appeal had nothing whatsoever to do with genetics and instead had but one primary consideration: “namely the welfare and best interest of this young woman, an interest which is conditioned by the imperative necessity of ensuring, for her own safety and welfare, that she does not become pregnant.”<sup>107</sup> He concluded his opinion by stating that he found the distinction between therapeutic and non-therapeutic sterilization as structured in *Re Eve* to be in the instant case “entirely immaterial,” for it clouded the paramount issue of the welfare of underage wards.<sup>108</sup>

In Australia, in the state of New South Wales, laws were approved in July, 1987 that ban the forcible sterilization of young women under eighteen years of age with intellectual disabilities. A newly created Guardian Tribunal will be required to rule on the feasibility of “medical procedures” being undertaken on intellectually disabled persons over the age of sixteen years. Previous to legislation, physicians either made the decision to sterilize on their own or — when unsure about the validity of a patient’s informed consent —

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100. *Id.* at 214.

101. *Id.*

102. *Id.*

103. *Id.* at 214.

104. *Id.*

105. *Id.* at 215.

106. *Id.*

107. *Id.*

108. *Id.* at 219. See generally Gillon, *On Sterilizing Severely Mentally Handicapped People*, 13 J. MED. ETHICS 59 (1987).

would appeal to the Supreme Court for a decision on the issue. The effect of these laws will be a recognition that since most intellectually disabled people are unable to give an informed consent to a sterilization, most such women under the age of eighteen will not be sterilized.<sup>109</sup>

### CONCLUSION

The comparative approaches to grappling with the very real problem of the mentally handicapped and both their rights and their coordinate responsibilities for executing those rights in a reasonable and responsible manner cannot conduce to one, unyielding response. Social externalities and economic costs are a crucial and, indeed, pivotal balancing point in shaping the extent to which reproductive rights will be recognized. A case-by-case or situational ethic will, of necessity, guide decision makers rather than blanket prohibitions either for or against sterilization.

It has been submitted that the concept of freedom should be viewed properly in terms of a social contract.<sup>110</sup> Thus, through the social contract, the citizen not only endeavors to maximize his own freedom, but assumes various societal *responsibilities* that, in turn, enable society to endeavor "to maximize its collective freedom."<sup>111</sup> Sterilization of the mentally handicapped as such — it has been argued further — frees the incompetent from both unnecessary and unwanted supervision.<sup>112</sup>

American society, while valuing freedom, also values equality — especially of opportunity. If sterilization serves both of these ends, it will not only make the social contract a more meaningful proposition to the mentally incompetent, but it will also serve the greater, albeit nebulous principle of justice.<sup>113</sup>

In all cases, the parent-guardian should be acknowledged as the person most able and responsible to protect and advance the best interests of the mentally handicapped or incompetent,<sup>114</sup> and thus meet the conditions and duties of the social contract. As the bulwark of society, the family unit alone should be given the determinative role here, thereby preventing an intrusive

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109. Coulthart, *Forced Sterility of Girls Halted*, Sydney Morning Herald, July 27, 1987, at 1, col. 2.

110. Comment, *Sterilization Technology and Decisionmaking: Rethinking the Incompetent's Right*, 2 J. CONTEMP. H. L. & POL'Y. 275, 301 (1986) [hereinafter, Comment, *Sterilization Technology*].

111. *Id.*

112. *Id.*

113. *Id.* See generally J. RAWLS, A THEORY OF JUSTICE (1971). Compare Michelman, *In Pursuit of Constitutional Welfare Rights: One View of Rawls' Theory of Justice*, 121 U. PA. L. REV. 962, 989 (1973).

114. Comment, *Sterilization Technology*, *supra* note 108, at 303.

and impersonal court from confronting the problem, with the physician continuing as a "conscientious and knowledgeable check on parental activity."<sup>115</sup> Reasoned analysis, not emotional passion, should be the watchword for action in this area of concern.

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115. *Id.* See *Parham v. J.R.*, 442 U.S. 584, 607-10 (1979); Smith, *Quality of Life, Sanctity of Creation: Palliative or Apotheosis*, 63 NEB. L. REV. 709, 740 (1984).

